	RVI	No RVI	p value
Shock (on admission)	23%	2%	< 0.001
Shock (in-hospital)	43%	6%	< 0.001
Ventricular arrhythmias	20%	8%	0.17
Complete AV block	30%	15%	0.1
Mortality	53%	17%	0.001

After adjustment for differences in age, infarct size, Killip class, LVEF, and development of complete AV block, RVI was selected as an independent predictor of in-hospital death (odds ratio: 9.1; 95% CI: 2.1–54; p < 0.01).

Conclusions: 1) The in-hospital fatality rate of elderly pts with a first inferior AMI complicated with RVI is very high. 2) The main cause of its poor prognosis is the high incidence of cardiogenic shock. 3) The in-hospital risk of death of elderly pts with RVI is independent of LV ejection fraction.

995-63 Outcome of Acute Myocardial Infarction in the Elderly: Does Gender Make a Difference?

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Although both gender and age are known to affect acute myocardial infarction (AMI) outcome, little is known about the relative influence of each, particularly in the thrombolytic therapy (TT) era. Accordingly, we evaluated the in-hospital courses of 2422 consecutive AMI patients (pts):

	Age ≤ 76			Age > 76		
	Male	Female	p	Male	Female	p
n (%)	1285 (73)	486 (27)	–	315 (48)	336 (52)	–
Age (yrs)	60 ± 11	65 ± 9	0.0001	81 ± 5	82 ±5	0.03
ST Elevation	57%	49%	0.002	34%	38%	0.27
TT Treatment	36%	29%	0.003	6%	7%	0.67
Hypertension	15%	15%	0.93	14%	19%	0.08
Death	7%	12%	0.0005	22%	20%	0.46

With these variables, a logistic regression model to predict AMI mortality was created. Female gender predicted mortality in patients ≤ 76 yrs; odds ratio (95% CI) 1.44 (1.01–2.00), p = 0.04. In contrast, female gender was not predictive of mortality in patients > 76 yrs; odds ratio (95% CI) 0.85 (0.57–1.27), p = 0.42. We conclude that both age and gender affect AMI outcome. The influence of gender, however, is not present in the elderly.

995-64 Quality of Life Changes After Angioplasty in the Elderly

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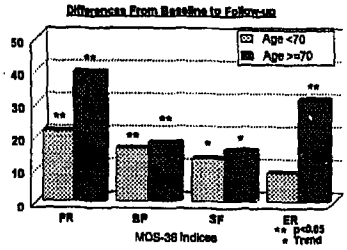
PTCA has been demonstrated to be effective in treating coronary artery disease in the elderly. However, the effect of PTCA on Quality of Life (QOL) in the elderly has not been fully evaluated.

Therefore, the Medical Outcomes Study (MOS-36), a well validated, quantitative tool to measure QOL, was administered to 113 consecutive patients, prior to and 6 months after undergoing elective PTCA. The MOS-36 includes 8 individual indices: physical roles (PR), bodily pain (BP), social functioning (SF), emotional roles (ER), physical functioning, general health, vitality and mental health. 39% of the cohort were > = 70 (Group 1), and 61% were < 70 (Group 2). The mean age was 63.5 (range 39–85). Demographics and PTCA results were similar in the two groups. Changes of the MOS-36 indices at baseline and at follow-up were compared between the two groups. Both groups had statistically significant increases in physical roles and bodily pain (p < 0.05) and a positive trend in social functioning. However, Group 1 had a statistically significant increase in emotional roles. There were no significant differences in the other indices.



In conclusion, 1) QOL after PTCA can be quantitated by using the MOS-36 in different age groups; 2) Age differences do exist in QOL changes after PTCA; 3) The elderly have more improvement in emotional roles; 4) Knowledge of QOL changes after PTCA in the elderly may assist in patient care and outcome measurements.

995-65 Prevalence and Prognostic Value of Predischarge Ventricular Ectopic Activity in Elderly Acute Myocardial Infarction Patients

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We studied in 1737 pts the prevalence of simple (Lown I–II), complex (Lown III–IV) ventricular ectopic activity (VEA) and nonsustained ventricular tachycardia (VT) on predischarge Holter, in elderly (≥ 65 yrs, 27% of population) and younger (< 65 yrs, 73% of population) AMI survivors. All pts participated in SPRINT study in 1981-3. 1-yr and 10-yr all-cause mortality rates were compared:

	Age	None	Simple	Complex	VT	p value
Prevalence	< 65	36%	38%	24%	2%	}0.001*
	≥ 65	26%	39%	32%	3%	
1-yr mortality	< 65	4%	3%	5%	8%	NS†
	≥ 65	7%	9%	9%	38%	<0.05†
10-yr mortality	< 65	22%	24%	34%	39%	<0.0001†
	≥ 65	41%	56%	56%	77%	<0.01†

*< 65 vs ≥ 65 yrs; †(p for trend) comparing mortality according to VEA.

For 1-yr mortality in multivariate analyses in young pts none of the VEA variables, including VT, had independent prognostic significance. In the elderly, VT was strongly associated with increased mortality (HR 7.12; 95% CI 1.83, 27.71), but not VEA frequency or complexity. *For 10-yr mortality,* in young pts only complex VEA (HR 1.49; 95% CI 1.13, 1.98) had independent prognostic significance. In the elderly, simple VEA (HR 1.49; 95% 1.15, 1.95) and complex VEA (HR 1.36; 95% 0.94, 1.96) were associated with increased mortality, but VT retained its strong prognostic significance (HR 3.57; 95% 1.74, 7.33).

Thus, VEA were of less importance in the young, but were independent contributors to the excess 1-yr and 10-yr mortalities observed in elderly AMI survivors.

995-66 High Short-Term Mortality of Elderly Patients With First Acute Inferior Myocardial Infarctions

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Acute myocardial infarctions of inferior location (IAMI) seem to have a better short-term prognosis compared with those of anterior location (AAMI) in the general population. It is unclear whether this difference in prognosis also apply for elderly patients (pts).

We studied 156 consecutive pts ≥ 75 years old admitted to the CCU with a first Q wave AMI. There were 84 IAMI (54%) which were compared with 72 AAMI. In-hospital fatality rate of patients with IAMI was 34%. Although 75% of patients were admitted in Killip class I, 41% developed left ventricular failure and other 17% cardiogenic shock (48% and 17% respectively in AAMI, p = NS). Compared with AAMI there were no significant differences in baseline characteristics, Killip class, maximal creatine kinase and MB fraction values except for the higher prevalence of diabetes in patients with AAMI (40% vs 23%, p = 0.02). Complete AV block was more frequent in IAMI (22% vs 0%, p < 0.001). In-hospital course showed no other differences between both groups. Mortality of patients with AAMI was 32% (p = NS).

Among pts with IAMI the risk of death was mainly related to the presence of right ventricular infarction (42%) and complete AV block (56%). Fatality rate reached 78% in pts with right ventricular infarction and complete AV block whereas it was 14% in those who did not exhibit any of the two complications.

Conclusions: Elderly patients with a first AMI of inferior location present a high in-hospital fatality rate. This poor prognosis seems to be mainly related to the presence of right ventricular infarction and/or complete AV block. The better prognosis of patients with inferior AMI compared with anterior AMI reported in the general population is not observed in an elderly group.

995-67 Is Dobutamine Stress Echocardiography Safe and Is the Echo Component Essential in Patients ≥ 75 Years of Age?

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Dobutamine stress echocardiography (DSE) has not been extensively eval-